Myths about Georgia Medicaid Managed Care

Myth: "Medicaid Managed Care is not working"

Georgia Healthy Families

Georgia Healthy Families, the new managed care delivery system for Medicaid and PeachCare for Kids members began June 1. We are entering the third month in the implementation of our program that involved a change for over 500,000 members.

Actually, the transition to managed care has gone relatively well –particularly when considering the magnitude of the change. Patients/members are receiving care and have available to them new services and options they had not had before.

Medicaid Member Inquiries

All call centers involved in Georgia Healthy Families receive inquiries from members and providers. There is no evidence from the call center metrics that members are having difficulty accessing services or receiving the necessary medical care.

Any transition of this magnitude will have challenges; however, managed care is working because the teams of health care professionals involved are working every day to ensure access to quality health care services for our members. The right care at the right time in the right setting remains our focus.

Myth: "Doctors and Providers are not going to get paid"

Provider Claims Payment

Providers are being reimbursed for care delivered. During the second month of transition there were 3-4 weeks of payment delays. And during that time some of those physicians were advanced interim claims payments. The claims payment dashboard below provides a snapshot status report as of 8/4/06. This dashboard will be updated weekly and posted on our website for public viewing.

Overview

The CMO Claims Dashboard reflects claims data at a specific point in time. This report summarizes CMO claims activity on a Year-to-Date (YTD) basis; that is, from June 1, 2006 to the most current week-ending period (each Friday). The YTD timeframes are included at the top of each worksheet. Please note that claims are received on daily basis by the CMOs and adjudicated several times each week. The CMO Claims Dashboard will be updated regularly and will reflect changes from the previous reporting period.

Claims Summary- YTD - (June 1 - August 4, 2006)

	Members	Claims Received	Claims Paid	Claims Denied	Claims Paid/ Denied	Amount Paid	% of Clean Claims Paid w/in 15 Business Days	Average Days to Process (Date of Service to Receipt of Clean Claim)	Average Days to Process (Receipt to Disposition of Clean Claim)
CMO Claims *	**589,899**	**440,571**	**300,375**	**90,409**	**390,784**	**$ 45,273,342**	**97%**	**11.3 days**	**5.3 days**
% Processed					**88.7%**				
Physician Claims **		**354,371**	**248,930**	**70,430**	**319,360**	**$ 20,087,053**	**97%**	**10.9 days**	**5.7 days**
% Processed					**90.1%**				
Facilities Claims		**79,834**	**47,154**	**18,550**	**65,704**	**$ 24,631,370**	**98%**	**15.2 days**	**4.6 days**
% Processed					**82.3%**				

* CMO Claims Total = Professional services, Facilities, Therapists and Ancillary Services (excludes Behavioral Health, Dental, Pharmacy and Vision Claims).

**All Physician types

Myth: "Managed Care Plans are not able to pay claims"

The three CMOs that provide health care services to our members all operate Medicaid managed care delivery systems, including claims payments to providers, in a combined total of 17 states and the District of Columbia. While there may be unique aspects specific to certain states, these organizations are experienced in processing and reimbursing claims for health services provided.

<u>Cause of Claims Processing Delays</u>
The number #1 reason for delayed claims payment occurs before the claims reach the CMOs and involves incorrect or incomplete filing of a claim by a provider office including omission of critical information such as the Medicaid provider number.

The other top **causes** for delayed claims processing are:

- Provider office claims management software not interfacing well with EDI vendors (private claims clearing house companies)
- One plan having initial difficulty with its own interface with the EDI vendors on the receiving end. This has recently been resolved and is being retested.
- Provider offices still trying to submit claims directly to ACS despite education on when to begin filing with the CMOs.

- Claims pending CMO review and prior authorizations

To assist providers during this implementation period, the CMOs have reduced some of the PA requirements and are strengthening their educational outreach to providers.

Providers are submitting supporting documents as they learn the claim submission criteria.

Myth: "Patients are not receiving care"

Members are receiving care and are doing so with the ability to choose their own doctor and health plan.

Member calls have mostly centered around inquiries on how to change plans and/or doctors.

There have been no reports of clinical adverse events.

In fact, during conversations with physicians even those expressing their concerns about claims issues and managed care in general– ALL have stated the patients have received care.

All providers contacting us have been urged to provide details and information immediately if there are any care issues. The Department of Community Health and the three CMOs have responded immediately to patient care issues that have come to our attention.

Myth: "The transition has been disruptive and not supported"

Transition of care from one delivery system (FFS) to managed care provider networks has required both advanced planning and ongoing on-the-spot flexibility to address quickly each arising situation. Most provider groups have been working with us to ensure each member receives the care they need.

Advance planning began in 2005 and involved the development of communications processes and system requirements as well as outreach and education for the members and providers.

Organized and regularly scheduled meetings and teleconferences are still occurring with provider groups including the Georgia Chapter of the American Academy of Pediatrics, the Georgia Chapter of Family Physicians, the Georgia Hospital Association and Hometown Health.

Myth: "Patients were stolen from my practice."

Medicaid Member Choice

Medicaid members are individuals who have a choice of who their doctor will be.

Medicaid members are not the exclusive property of certain providers. Medicaid patients are encouraged to make health care decisions that best meet their individual needs or those of their family.

When members do not state a choice they are auto-assigned to a health plan based on:

(1) efforts to keep them together with a family member if a family member is already in a CMO,

(2) their previous relationships with a physician in a CMO, and finally,

(3) to a random plan if the two conditions above do not exist

Medicaid members continue to have the ability to change their health plan for 90 days after their program effective date and can change annually after that similar to what is available to people in commercial health plans. Members are able to change their primary care physician at any point in time.

Myth: "The CMOs have not tried to honor their obligation to pay claims electronically"

Contractual obligations: Electronic Claims Submission

There are contractual obligations on the part of the CMOs to process and pay claims at a minimum, once per week. Each CMO is required to encourage providers to submit and receive claims information through an electronic data interchange (EDI).

All CMOs are now able to process claims payments via an electronic fund transfer (EFT).

Plans are required to address as quickly as possible any of their own systems problems hindering claims processing and, in the interim, must provide a plan for alternative claims payment timely.

There are also contractual obligations on the part of providers to send and submit claims.

Submitting Provider Claims

If a provider fails to file a claim within 120 calendar days of the date of service, the CMO may deny the claim. A CMO must deny any claim not initially submitted to the CMO by the 181st calendar day from the date of service. If the provider files erroneously with another CMO or DCH, but produces documentation verifying that the initial filing of the claim occurred within 120 calendar days, the CMO will process the provider's claim without denying for failure to file in a timely manner.

Myth: "Claims will be paid late"
In the contract between DCH and the CMOs, a Clean Claim is defined as follows: "A claim received by the CMO for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment or alteration by the Provider of the services in order to be processed and paid by the CMO."

Prompt Pay & Late Penalty Fee
Under the terms of the DCH and CMO contract, as well as Georgia law, the CMOs are required to pay providers for clean claims within 15 business days of receipt. If a CMO fails to pay a clean claim within this timeframe, the CMO must pay an 18% penalty on that claim. AMERIGROUP and Peach State pay such interest penalty with the actual claims payment, while WellCare makes separate monthly interest payments to the applicable provider for any late payment for a clean claim.

Coding Errors Delaying Claims
If a provider submits a claim that requires additional information or an adjustment to the initial information, the claims may be denied or pended by the CMOs.

The most frequent claims coding errors have been:
- Missing or incomplete provider Medicaid ID numbers,
- Mismatched Medicaid ID numbers and TINs
- Incorrect location of Medicaid ID number on the claim
- Absence of Medicaid ID numbers for secondary practice locations
- Incorrect location codes for Health Check claims and vaccines
- Ineligible member
- Services rendered before 6/1/06 effective date of Georgia Healthy Families (these claims should have been submitted to ACS)

If a CMO denies or pends a claim because of coding errors, the provider should receive information regarding the necessary adjustments needed to process the claim as a clean claim. Each CMO continues to work with providers who still have issues with claims coding that may result in delayed payments.

DCH monitors each CMO's average time to process clean claims, as well as the percentage of clean claims processed within 15 business days. In addition, DCH monitors the percentage of claims that are either pended or denied by the CMOs to determine if providers may need additional education on claims coding and billing.

Myth: "Doctors are not in the network and credentialing of providers is being delayed."

Despite early and proactive outreach to providers, some providers did not contract with CMOs until right before implementation or after CMOs began providing health care to Medicaid and PeachCare for Kids members. Providers must be properly credentialed by

the respective CMOs before they are considered a network provider with the ability to submit claims for reimbursement.

In the early stages of building provider networks, CMOs focused heavily on recruiting hospital facilities and credentialing primary care providers.

Participation as a Medicaid provider under the CMO networks does not reflect an "any willing provider" status.

Provider Applications

Application to participate as a CMO provider does not guarantee acceptance. Acceptance of a provider into any of the CMOs is based on a number of factors: 1) clinical expertise and history of quality care; 2) business decision based on network need, 3) contractual agreement, and 4) completion of credentialing process.

Credentialing

Credentialing is carried out by both hospitals and managed care organizations to ensure that only qualified practitioners with current demonstrated competence have practice privileges at the hospital or other type of health care facility and they practice within the range of their expertise and abilities.[1]

Expedited Credentialing

All CMOs have implemented an "interim" credentialing process to expedite the participation of providers in the Georgia Healthy Families. The "interim" plan is in place on a temporary basis and does not negate any of the requirements to meet full credentialing.

Myth: "Managed care is all about cutting cost and not about quality care"

Managed care is about providing the right care at the right time by the right provider. This means ensuring access to preventive and acute care in a coordinated environment. It does not mean cutting costs at the expense of the patient's medical needs.

Unless individuals are considered private pay, some aspect of their care is managed whether they are in a public or commercial health plan. Georgia's Medicaid program has included a form of managed care, Georgia Better Health Care, for this same population statewide since 1998.

Per the contract terms with DCH, all CMOs are required to be accredited by a recognized national accrediting body, such as the National Committee for Quality Assurance (NCQA) within 3 years of operating in Georgia. To meet the minimum standards to be considered for selection as a CMO in Georgia Healthy Families, these organizations must have been accredited in other states.

DCH requires all CMOs to achieve performance improvement directly related to improved patient outcomes:

- Improving health check screening rates
- Improving the rate of immunizations
- Improving the rate of blood lead screening
- Improvement in the screening or detection of chronic kidney disease
- Improvement in the treatment and management of asthma

CMOs as part of their health strategy have quality initiatives in place for their respective members. These quality initiatives include:

- Kidney disease
- Asthma
- High risk pregnancies
- Sickle cell anemia
- HIV/AIDS
- Major depression
- Schizophrenia

Myth: "Members don't have access to specialists"

In some areas of Georgia, there are inadequate numbers of specialists regardless of the type of insurance, especially in the pediatric specialties.

The CMOs have contractual requirements to have at least one specialist available within 30 miles or 30 minutes of the member's home in urban areas, or 45 miles or 45 minutes of their home in rural areas.

CMOs are required to pay a non-participating provider if, at the time of medical need, a CMO provider is not available.

All CMOs continue efforts to expand their provider networks to increase the participation of specialist.

Notes:

[1] Managed Care Desk Reference, Marianne Fazed, Ph.D., 1994